

NEW WORKERS, DEPRESSED WORKERS?

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Abstract

Major changes in the workplace brought about through economic reforms require workers to be autonomous, flexible and mobile. One effect of these changes has been a major increase in the incidence of worker anxiety and depression (Gabriel & Liimatainen 2000). According to this survey, depression in the workplace had become the second most disabling illness for workers after heart disease.

This paper reports on research into workplace depression, investigating the potentially deleterious effects of major workplace changes on the workers' wellbeing. New work practices, it argues, intensify uncertainty. To succeed, the new worker must manage these uncertainties as well as produce themselves as flexible, autonomous and mobile subjects. The overall research project seeks to understand how workers construct themselves as depressed, and to account for the ways that workplace depression is now positioned as a global economic problem. Within that broad framework, this paper argues that there are three dominant discourses of depression: bio-medical, psychological, and pharmaceutical, that are deployed to manage and treat depression as a disorder of the individual and effectively disavow the social contexts and determinants of the phenomenon.

I. Introduction

Being unhappy at work, or worried about work, or anxious about your job has become a commonplace in social and workplace conversations. By the close of the twentieth century, worker unhappiness has been identified as a key problematic, as indicated by the growing proliferation of international surveys, research journals, conferences, newspaper feature articles, television documentaries, internet sites, and self-help guides dedicated to the analysis of this topic. Many terms are used to capture this phenomenon: stress, burnout, unhappiness, anxiety and, increasingly, depression. 'Workplace depression' and 'worker depression' have been named and measured as key economic indicators through large-scale global research on productivity loss, etc. As workers have moved beyond the construction of being 'cogs in a wheel', to 'new workers' with an emphasis on knowledge as well as technical skills, and on qualities of flexibility and increasing

mobility etc, there are reports of increased anxiety and stress levels for workers, as well as an unprecedented number of people with workplace depression. The following excerpt from the major International Labor Organization (ILO) report titled *Mental Health in the Workplace* Gabriel & Liimatainen (2000ⁱ) states that ‘costs of workplace stress are rising, with depression increasingly common’ (1):

A major finding of the report warns that the incidence of mental health problems are rising with as many as one in ten workers suffering from depression, anxiety, stress or burnout .. Employees suffer from low morale, burnout, anxiety, stress, lost income and even unemployment associated in some cases with the inevitable stigma attached to mental illness. For employers, the costs are felt in terms of low productivity, reduced profits, high rates of staff turn over and increased costs of recruiting and training replacement staff. For governments, the costs include health care costs insurance payments as well as the loss of income at the national level (Gabriel & Liimatainen (2000)).

The ILO conducted the first major workplace survey examining mental health in the workplace in 2000. It covered Finland, Germany, Poland, United Kingdom and United States. Since then, there have been numerous more recent surveys, including in Australia, where the research reported in this paper was conducted. Large-scale Australian research just released (October 2005) surveyed 7,1000 workers. It has found that 56% of the Australian workers surveyed are unhappy with their jobs, according to Seek Survey of Employees Satisfaction and Motivation (Press Release, *The Daily Telegraph* October 25, 2005ⁱⁱ)

The principal theme running through each of these major surveys appears to be economic concerns: for the workers in terms of costs to manage their mental health problems and loss of wages, for the organization staff turn overs, loss of productivity, and reduced profits, and for the government, health care costs, and national loss of revenue. Gabriel and Liimatainen (2000) estimate, for example, that anywhere from 3-4% of the Gross National Product is spent on mental health problems in the European Nation. In the US national spending associated with the treatment of depression ranges between US\$ 30- to US\$44 billion.

The research discussed in this paper is an inquiry into the rise of ‘workplace depression’ as an unprecedented historical event – as overwhelmingly a phenomenon of the past two

decades (Mathers, Vos, Stevenson, and Begg, 2000)ⁱⁱⁱ. Through the governance of neoliberal political philosophies and economic policies accelerating globalisation in the past two decades, workplaces have undergone a series of quite radical shifts that have changed the way that work is experienced by workers. This research investigates the ways that workers manage workplace change and interact with other workers through the effects of implementation of these economic reforms. Focusing on workers who experience themselves as depressed at work, the study investigates their responses to coping with uncertainty and instability in the job.

One of the problematics of this area of inquiry is that workplace depression is managed almost exclusively through the bio-medical apparatus that individualises and pathologises workers through the mechanisms of diagnosis and treatment. In seeking to counter the effects of dominant biomedical discourses for the management of workplace depression as an individual psychopathology, this research attempts to illuminate the relationship between the experience of depression by workers and their experience of the effects of workplace change. These experiences, such as increased uncertainty, instability and a sense of increased surveillance, are currently excluded from consideration through the almost exclusive deployment of bio-medical discourses of diagnosis, treatment and management of depression as individual psychopathology.

This paper takes up one major thematic of the overall research focus: that of depressed workers' constructions of their workplace and their work, their understandings of themselves as depressed and their experiences of diagnosis and treatment. The participants in the research study volunteered as people understanding themselves to be suffering from workplace depression to be part of an in-depth interview study. These participants describe their workplaces at length as they tell their stories of how they come to seek assistance with depression. Through their descriptions of their workplaces and their experiences of work, major thematics are identified that powerfully link their experiences of their workplace with their experiences of distress. What emerges is a very different story of depression from those produced through dominant biomedical discourses. In the next sections of this paper, we briefly sketch a progression in the

narratives of several of the participants in the study, in order to illustrate the inter-relationships between the participants' experiences of workplace change and the recognition of themselves, through diagnosis and medical treatment, as being depressed.

This paper seeks to contribute to the research literature on work and learning by casting a direct lens on the phenomenon of breakdown of effective functioning and wellbeing at work. It argues that breakdown, managed commonly through a medical diagnosis of 'depression', is not simply an accidental co-occurrence with major structural and procedural changes in workplace practices and relations. Rather, it is both an inevitable effect of such changes and is simultaneously managed through discourses and practices of globalised neoliberal economies. Put bluntly, depression as an overwhelmingly contemporary social phenomenon, is both a source of economic concern and a consequence and effect of the same politico-economic rationalities – in the form of multi-billion-dollar global bio-medical, pharmaceutical and 'psy' industries.

A particular issue of concern is the simultaneity of the rise of the diagnosable medical phenomenon of 'depression' with the large-scale social and economic changes mentioned here. That is, at the same time as depression is captured in medical and economic statistics of disease pandemic and productivity loss, it is arguably itself a discursively produced phenomenon of the same political and economic rationalities. We return to a consideration of these matters in the conclusion of the paper.

II. The research: 'new workers, depressed workers?'

The research from which the material in this paper is taken is a doctoral study drawing on poststructuralist theories of discourse and the subject to explore and illuminate the experiences of workers who understand themselves as depressed at work (West, in progress^{iv}). This research seeks to inquire into the relationship between workplace change and the increase in the incidence of workplace depression, as measured and represented in the survey statistics cited in the Introduction.

An in-depth interview study was conducted with twenty volunteers who were willing to discuss their experiences of changes in their workplace and their depression. As an open recruitment strategy, an article was published in *The Sun Herald* on June 1, 2003^v: 'Six million sickies due to stress' cited this research project with an email address to contact the researcher if they were interested in participating in an interview study. There was a strong response with 80 emails were from people wanting to take part. Out of this group, ten men and ten women were selected with an age range of 23 to 60 years of age. They represented a range of demographic characteristics and levels of education and all were working full time.

Nine of the participants were on anti-depressant medication at the time of the interview, and the remaining eleven had tried pharmaceutical intervention at some time, but chose not to continue. All participants described themselves as having depression, or as being depressed. Twelve were diagnosed by their local doctor, four were receiving treatment from a psychiatrist, and three were seeing a counselor on a regular basis. All of the research participants viewed the changes in the workplace as a contributing factor to their depression, though they had difficulty in explaining what the exact nature of the link between changes in the work place and being diagnosed with depression.

The research seeks to describe the ways that workers have come to understand and position themselves as depressed at work. It draws on poststructuralist forms of discourse analysis, particularly influenced by Foucault, to show how workers who experience themselves as depressed, and receive diagnoses of depression, understand and 'produce' themselves within the terms of available discourses. The forms of discourse analysis used in this study takes the term 'discourses' to refer to the 'macro-level' of structural orders of discourse (Foucault, 1971)^{vi}: broad historical systems of meaning including any meaningful political practices (referred to as 'discursive practices'), which are relatively stable over considerable periods of time. These practices produce subjects, forms of identity or self-hood that are constructed in the context of available systems and relations of meaning. Importantly, these forms of self-hood or subjectivity need also to be understood as constituted within institutionalised relations of power. Discourses around

major identity-markers such as national identity, sexuality, gender or race – or illness or wellness – are not autonomous systems but operate in the context of the institutional supports and practices that they rely upon (Mottier, 2000)^{vii}.

Foucault (1972, 1977)^{viii} understood language as a means of constructing and mediating social order and power. Much of his analysis is based in the clinical environment of doctors, prison governors, social workers, and psychologists. He noted the way that language functions as a means of which social identity is expressed and power relationships are exercised. For example professionals can ask certain questions of clients that are licensed by their professional body, and in turn can select what is admissible and what is deemed irrelevant.

Through the workings of powerful institutionalised forms of discourse such as biomedical discourses, power is exercised, knowledge is generated and subjects are formed and governed. In addition, they come to understand themselves as properly constituted subjects within the terms of those discourses. The primary discourses at work in the material in this paper are those of the ‘new workplace’ and of ‘depression’; as these are mobilised and taken up by these depressed workers in their stories. In particular, in these participants’ accounts it was not uncommon for the workers to seek a medical opinion regarding the changes in the workplace and the effect that it was having on them. Though not clearly or specifically articulated, there seemed to be the idea that the doctor was the only professional person that had the legitimate means to listen to what they were feeling, but also to provide them with defensible time off work.

III. How did this happen?

This section of the paper briefly outlines three key stages in the accounts given by the participants in the study of their experiences of difficulties at work. These three stages are produced in response to three key lines of questioning by the interviewer. The first is the participants’ experiences of their workplace and their work, including their experiences of distress; the second moves to their consultation with a doctor, the diagnosis of depression, and the third deals with their subsequent experience of treatment. The

participants in the study had all received a diagnosis of depression and had been prescribed SSRI antidepressant medication. For reasons of economy, we then focus on what we term a ‘fulcrum’ moment in the stories: the second stage where the workplace experience gives rise to a diagnosis of depression.

In this study ‘the workplace’ is not presented as a coherent, stable or unitary entity. Different interviewee accounts construe workplace change in many different ways. They articulated a mixture of circumstances that reflected the diversity, complexity and contradictions in their experiences of work place change. Types of workers interviewed included computer consultants, a Work Cover inspector, a call centre operator, teachers, an auditor, an accountant, a journalist, a human resources consultant, a recruitment consultant and a social worker.

Constructions of work and workplace change

In terms of the first stage of the interview accounts, most of the participants were very articulate about their experiences of their workplace and provided coherent, sequential accounts of these changes. Perhaps not surprisingly, the dominant discursive construction of the workplace throughout these interviews is *change*. It is change that produces uncertainty and stress in these stories and shapes their subsequent constructions of depression. Change relates to the rapid changes in management, changes in procedures, reduction in the numbers of staff, increases in technology, policy changes, meanings of work, types of work, conditions of work, the distribution of work, re-structuring, relocations, downsizing, moving work off shore, threats of closure of the organization, and the expectations of unpaid work – the 24/7 worker. Their stories are common and predictable. Alice, for example spoke of downsizing and intensification:

Downsizing - that’s a lot of stress on you as a person and the department you know. They expect you to function as you were with half the resources you had previously that drives me absolutely insane.

John articulated the common and recurrent theme of uncertainty and not-knowing:

With all these changes people just didn't know whether they had a job or didn't have a job. No one had much motivation because they did not know if we were going to be taken over and retrenched, taken over and restructured, or not taken over and go back to the old ways.

Closely related to the theme of change in the participants' stories is the experience of increased *surveillance* in their workplace. This relates to the changes in the complexity of work, the pace of work, automated and manual levels of reporting, including worker accountability, worker monitoring, and worker surveillance. These increased complex mechanisms, termed the 'technologies of performance' by Dean (1999:169^{ix}) are utilized by management from above via performance indicators, benchmarking, cost centers and budgets as instruments of control. These technologies of performance provide ways for workplace management to map the productivity of specific work places and workers to plan, develop, and implement future 'moves'. In the interviews these 'moves' include the number of redundancies to be offered, shutting down of work areas, organizational relocation, downsizing, mergers, or moving the work/workers 'off shore' where the costs of employment and labour is more cost effective. Paul articulates a common thematic of loss of trust:

Paul Well it is a sense of being under surveillance when everything you do has to be documented... there seems to be this constant check and balances ... it's a feeling of lack of trust.

Alice again speaks of a common sense of operating under increasing management expectations:

[management] have increased the expectations of what you will do in the next twelve months there's always this curb this gradient you've got to do better – the next time you will have the same number of people allegedly working for the same number of hours but the expectations of what the management want from you is higher from year to year.

Related also to the thematic of change was the prevalence of experiences of *loss*.

Participants related their stories of their workplace in terms of having lost some part of

their work, their role, their sense of belonging, having adequate skills, loss of support, loss of stability, loss of direction, and workplace sociality. For some participants there was a prevailing sense of uncertainty, disconnectedness, disenchantment and abandonment as workplaces restructured and reformulated their work. For Mark the loss was a loss of certainty:

My greatest fear was that *I did not know what I was doing...*
so I was pushed off to sail my own ship, we won't tell you
where we are going, but is where you have to go that *to me*
was totally humiliating.

For Heather the experience was a loss of place:

You just have to set aside all that theoretical stuff it belongs in
another world and in the real working world what I was doing
was not the way the culture operated here. *I was nothing,*
neither the grass roots or part of the administration *I was*
somewhere in between and finding my place and number.

The discourses being mobilised here are increased losses in many aspects of work: loss of direction, being accepted, certainty, being visible, loss of support and loss of skill. These participants in the interviews could be seen to be taking up subject positions within a workplace discourse coloured by loss. Foremost among the losses articulated is the loss of the capacity to self manage. Prior to the period of recent workplace changes, both Mark and Heather described a time when they all had sense of pride and competency in their work, where they felt that their skills matched their specific occupations. Heather wrote education policies, Mark was a police inspector. With the introduction of major workplace change through extensive restructuring, each was required to take on very different roles and responsibilities. These in turn involved the need for retraining in different aspects of their new work. The retraining became problematic as their co-workers were either much younger or people who had been doing similar jobs for some time and were perceived by the participants as competent with the required new workplace skills.

The reconstructions of the stories told by Mark and Heather fluctuate between blaming the management as the source of their problem and blaming themselves – seeking a

solution by taking up a pathologising, individualising, psychological discourses that constructed them as having the problem. Heather says *I was nothing* – constructing her self in her account as being invisible or being in the space that is waiting for a place and number.

Diagnosis of depression

In the second stage of the stories, the participants were asked to describe their decision to take sick leave and consult a doctor, followed by their experience of diagnosis. The participants were first asked why they sought the advice of a doctor when they realised their difficulties with their workplace. The following response from Alice was indicative of the kinds of answers given:

it's just sort of ingrained it's a societal thing if you have something wrong with you go to someone who can help you .. you know. I had health problems associated with personal and work related stress and the first thing you know you go to a GP thinking well if I can solve that that might make everything else better.

This response is important in that it introduces the notion of how particular kinds of discourses shape and constitute our experience of problems. Alice has engaged with bio-medical discourses as a way to describe and talk about her experience: *the first thing you do is to go to a GP*. This appears to be an automatic response to the experience of adversity in her life, helping her to maintain her belief in the prowess of the medical profession in contemporary society: *it's sort of ingrained it's a societal thing*.

This handing over of individual control over one's life events in this study is one of the major characteristics of all of the participants' accounts

Bill visited his doctor for a 'blood test' for fatigue. He construed the role of the doctor in his account as a person who has the credentials to examine his blood for any pathology and, if required, treatment for his possible disease. Bill had put off the visit to the doctor as he had financial problems related to building extensions on his home. In the interview he said that he did not want to waste the money on a visit to the doctor when his cash flow was very low. His father had experienced bankruptcy on three occasions and he was

worried that he may go the same way. He worked from home, and enjoyed his autonomy and the creativity of his work. When Bill finally did consult the doctor, he was diagnosed with depression.

I said look I'm just extremely tired I think I'd like to have a blood test I feel like I'm something's missing. Are you eating well? Are you sleeping well? I said no I've always been a light sleeper and I still didn't put two and two together where she was taking me she went through my job a bit and she said well you're suffering from depression. It was a funny feeling it was like someone dropped a truck full of bricks on me it was like what ? but that's not what I'm here for .. you just need to give me a blood test and I'll be right [laughter]. So it stunned me that I actually had depression - it's more serious than I thought - I was you know to me ... oh so I was stunned and then from there she said I think you should maybe see a counsellor or a psychologist so she gave me a name.

It is interesting to note that following Bill's initial reaction of incredulity, he resorted to laughter as he said to his doctor *you just need to give me a blood test and I will be right*. However, Bill did not pursue his original request and proceeded to consent to becoming medicalised in relation to the depression diagnosis and the prescribed treatments.

Treatment

The third stage in the participants' stories concerns their experience of treatment and their reconstructions of themselves as depressed. All participants were prescribed antidepressant medication.

Mark was a newly appointed Police Inspector who had worked mainly in a administrative role in the ombudsman's office for the past fifteen years prior to his workplace change. With a change in Government and a new commissioner of police, his work was dramatically re-organized. Mark was relocated to the position of an area commander in a very busy inner city police station. He describes his readjustment as huge: *I had not been involved in operational policing for thirty years*. His major concerns were the lack of training for the new role in terms of computer programs for data entry, police vehicles, and returning to shift work. He spoke of his humiliation regarding having to continually ask his staff to assist him with what he considered to be routine police tasks. Subsequently he became stressed about his work and after some time saw his GP.

L: What did that feel like to get the diagnoses what did it mean to you?

M: Ah it meant obviously it meant that my ideas of controlling my life were starting to be controlled.

L: Can you expand on that?

M: Well there were external forces that things were happening to me and I'm there which I really had no control over. If I had control I could have walked away. But I'm not the sort of person to walk away from anything so: I finished up getting medical assistance and medical attention in relation to it. So that medical attention then consisted of ah Zoloft and then sort of again increasing dosage uhm I finally went off sick in May 2000.

Mark experienced his diagnosis as losing control. The change in his work role and the associated stressors appeared to have segued him from having some control over his life to being controlled by others. Coming from a responsible position in charge of others he now sees himself as being controlled by, the police medical service in terms of his, medication, sick leave, and unanticipated early retirement. His diagnosis of depression was a major turning point in his life. He was a fit healthy man in his late forties that became a depressed worker.

IV. The biomedical discourse on depression

The account in the previous section briefly sketched part of the process whereby the participants in the interviews experienced stress at work wrought by workplace change and subsequently arrived at the point where they were diagnosed and subjected to medical and pharmaceutical intervention.

As we indicated in the Introduction to this paper, depression is now predicted to become the second largest world health problem by 2020 (G & L 2000, Mathers et al (2000).

Workplace stress, and its pathologisation through diagnosis into illnesses such as depression, has reached pandemic proportions in contemporary society but this has not always been so. Until the 1980's, most medical experts believed that up to 89% of all cases would cure themselves (eg Cole, 1964, Kline, 1964, Byck, 1975^x). Since that time, there has been a revolution in the diagnosis and treatment of depression.

This major shift was achieved through two principal simultaneous developments. The first was the production of Prozac, the first of the selective serotonin reuptake inhibitor (SSRI) group of drugs. Prozac was launched in the early 1980's and sparked a revolution in the treatment of a hitherto untreated range of conditions. Billions of marketing dollars

were spent in promoting the idea that people could feel ‘better than well’ Breggin and Cohen (1999:67)^{xi}.

The second development, coinciding with the launch of Prozac, was the official reformulation of the condition of depression, through the Diagnostic and Statistical Manual of Mental Disorders Third Edition (1987:222).^{xii} This manual (known commonly as the DSM-III-R and later the DSM-IV, published in 1994) is the contemporary psychiatric touchstone, used by health professionals of all disciplines and cited for insurance, forensic, disability matters and diagnostic categories for mental health. A history of depression read through the four editions of the DSM since its first publication in 1952 is instructive. The DSM-I listed 106 ‘diagnostic entities’ for depression. In contrast, this has expanded to 307 categories for depression in the DSM-IV (Parker (2003).^{xiii}

Different research assigns different primacy to the causes of depression such as biological, biomedical, genetic, physiological, hormonal, familial, situational, psychological and pharmaceutical. In the absence of any absolute diagnostic test for depression, the diagnosis of a ‘depressive disorder’ remains problematic (Aldridge 2002)^{xiv} While the DSM-IV is used as a diagnostic tool, it does not attempt a definitive causality of depression. One powerful consequence of this expansion of categories of and for depression is that there is literally no exclusion criterion for what constitutes depression.

Medical discourses inform popular notions of well-ness and the ways that happiness is an achievable condition if people seek help and follow the treatment ordered by their doctor. Historically medicine’s role was to treat diseases that had demonstrable *pathology*. Evidenced by signs such as swelling of joints, what the patient complained of symptoms and blood tests that provided scientific evidence of abnormality. These three factors were necessary before a diagnosis was made either provisional or definitive. A clinical diagnosis of depression, however, requires little else than a short history of symptoms. Blood evidence of an increase or decrease in serotonin levels in the body are

not routinely measured, and abnormal signs (on the body) rarely exist. Hence the most commonly used diagnostic tool used by doctors is the lexicon of depressive symptoms that the patient brings/knows to the consultation.

A major tangible effect of the diagnostic changes noted here, and the aggressive marketing of antidepressant drugs, is a dramatic increase in the prescription of antidepressant medication (Rose, 2003). In Australia alone in 2004, three billion dollars were spent on anti-depressant prescription drugs (Bell, 2004). It is clear that there is a powerful discourse of depression governing the diagnosis and treatment of dramatically increasing numbers of people presenting to medical practitioners with symptoms of distress.

One explanation for this phenomenon is offered by U'Ren (1997)^{xv} who argues that the logic of capitalism is such that new markets have to be created for existing and new products. Similarly, in order to create and maintain a market share for its services, psychiatry must enlarge the public's awareness of the problems that it can treat. This is done by expanding the diagnostic criteria, so that more and more experiences are brought within its domain. The way that depression is now formally defined has not only expanded the market, it has created a legitimate instrument for promotion and advertising. According to U'ren, this in turn works as an increasingly powerful instrument of social control.

U'ren's analysis is a useful account of the symbiotic relationship between the biomedical production of an expanding depression discourse and the logics and imperatives of market capitalism. However, to leave this analysis as one merely involving subjection to more or less coercive or manipulative regimes of truth and power is to miss an important aspect of Foucault's understandings of the workings of discourse. In elaborating the idea of subjectification, or subjectivity from a Foucauldian perspective, Burchell (1990^{xvi}) would argue that particular kinds of knowledge and discourse structures individuals' own self-understanding and practice, such that their own desires, aspirations will become connected with the wider governmental objectives and aims. Alice, for example, willingly recruits herself into the medical system, appearing to understand her decision as

almost made for her by the *societal thing*. Bill, too, appears to acquiesce in his diagnosis, after his initial incredulity, seeming to believe that his condition really was as the doctor diagnosed and more serious than he had thought.

Rose (1990^{xvii}) points out that psychological discourse and knowledge is a key meeting point between the ways that authorities seek to govern individuals and how individuals understand and act upon themselves. The focus here is on the relationship constructed between doctor, who has the capacity to make a diagnosis the ‘truth’ as a professional who can ask certain questions of clients that are licensed by their professional body, and in turn can select what is admissible and what is deemed irrelevant. In the previous examples given by Mark and Bill we can see that despite different responses, and different outcomes from the diagnosis the diagnosis itself was not disputed.

Different medical discourses have, over time, provided important systems of knowledge and related practices by which we have not only understood but also experienced our bodies (Petersen and Bunton 1997^{xviii}). The Foucauldian approach taken by these health sociologists and policy analysts contends that there is no such thing as an ‘authentic’ body that exists outside medical practice and discourse. The body and its various parts are understood as constructed through the ‘clinical gaze’ exerted by medical practitioners. Hence ‘a body analysed for humours contains humours; a body analysed for organs and tissues is constituted by organs and tissues; a body analysed for psychosocial functioning becomes a psychosocial object’ Armstrong (1994:25^{xix}). Bill’s encounter with his doctor in the previous section could be understood as an effect of the disciplinary power of biomedical discourses about depression as they provide guidelines about how he should understand and regulate his body.

In attempting to understand the ways that there appeared to be such little resistance to the diagnosis of depression by the participants in this study, we could hypothesize that workplace change as yet has no discursive ‘body’ upon which to inscribe meanings, as there is on the disciplinary regimes and apparatuses that surround the body in a medical context. Workplace change and its discursive effects may thus usefully be seen as

‘subjugated knowledges’ – those knowledges that tend to be buried and disguised beneath more dominant, more scientific, more expert knowledge – in this instance knowledge produced through bio-medical discourses of depression.

V Conclusions

In published research on workplace depression to date, the diagnosis of depression appears to exist as a stand-alone condition that is treated and managed as a separate entity from the workplace within which it is experienced. Overall, it appears that workplace stress is acknowledged by medical practitioners who produce diagnoses that can be measurable in the statistics cited in the Introduction to this paper. Yet the symptoms that arise from the stress are treated as a medical condition, an individual psychopathology. There is no effective relationship that can be established between the circumstances within which the phenomenon of workplace depression is constituted and experiences and the treatment post-diagnosis. Of course, medical practitioners are positioned as the only gateway through which a worker can pass to obtain treatment. Hence the institutionalisation of medicine as the sole provider of an authoritative discourse about the phenomenon creates the phenomenon. In that sense, the assemblage of statistics and the global pandemic are a powerful effect of discourse.

At the same time, workplace change brought about through economic reform has had wide-ranging effects on workers’ well-being. In seeking ways to understand how workers construct themselves as depressed, this study begins the work of demonstrating a transitional process of moving from accounts of workplace stress to medicalised constructions of depression and treatment. The management of depression is achieved through medical technologies of diagnosis and treatment and the recruitment of these participants into these discourses. The conditions under which the depression was experienced are occluded. This paper raises questions about the complex apparatus of governance of the new workplaces through globalised discourses of capital and labour, whereby the ‘global pandemic’ of workplace depression is both a source of economic concern and an occasion for the mobilisation of a multi-billion dollar medical, psy and

pharmaceutical industry. Within this complex, some major issues of the effects of major economic and social change on workers themselves need to be further investigated.

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